

your**choice**

Policy Document

Effective from 1st March 2012





“The service we received was exemplary and the efficiency of response outstanding. The product is excellent value and I’m delighted to have found CS Healthcare.”

Mr C Drinkwater



Contents

Introduction	4
Advice Lines	4
Member responsibilities	4
General Terms and Conditions	5
your choice health insurance – summary	5
Schedule of benefits	
Essential – schedule of benefits (D1)	7
Expert Diagnostics option – schedule of benefits (D2)	9
Therapy & Care option – schedule of benefits (D3)	10
Heart & Cancer option – schedule of benefits (D4)	11
Cash Benefits option – schedule of benefits (D5)	14
The Your Care Package	14
Claims procedures	
How to Claim for Health Insurance	15
How to Claim under the Cash Benefits option	17
How we deal with Chronic and Acute conditions	17
Claim Terms and Conditions	20
Policy Exclusions, rules and additional information	
General Policy Exclusions	21
Specific Treatment Exclusions and Advice	23
Policy Administration	26
Voluntary Excess and Co-payment Options	28
Underwriting Terms and Personal Exclusions	28
Switching your health insurance to CS Healthcare	30
Policy Rules	31
How to make a complaint	31
How we use information about you	32
Definitions	33
Schedules	
A Policy Document	
B Directory of Hospitals	
C Contribution rates	
D Benefit Schedules:	
D1 Essential – schedule of benefits	
D2 Expert Diagnostics option – schedule of benefits	
D3 Therapy & Care option – schedule of benefits	
D4 Heart & Cancer option – schedule of benefits	
D5 Cash Benefits option – schedule of benefits	

Introduction

This Policy Document sets out the details of **your choice** health insurance; including all policy rules and guidance notes. Please refer to your Registration Certificate for confirmation of the options you have chosen, for the details of the persons covered under the policy, any restrictions that may apply and any voluntary excess or co-payment option selected. Under **your choice** health insurance there is a compulsory level of cover: Essential alongside four additional options: Expert Diagnostics, Therapy & Care, Heart & Cancer and Cash Benefits. It is important that you read this Policy Document carefully and in conjunction with Schedule B: Directory of Hospitals, Schedule C: Contribution rates and Schedule D: Benefit Schedules (found within this Policy Document).

If you would like this Policy Document or any of our literature in a large print, audio or Braille format please contact our Membership Services Team.

Advice Lines

For general enquiries call our Membership Services Team on 020 8410 0400*

Lines are open Monday to Friday (excluding public holidays) from 9am to 5pm.

For requesting a Claim Form and pre-authorising treatment call our Claims Helpline on 020 8410 0440*

Lines are open Monday to Friday (excluding public holidays) from 8am to 6pm.

For 24 hour advice on health issues call our Lifeline on 020 8410 0415

We offer a health advice and assessment service, with Doctor call back, called Lifeline. This service is staffed by experienced nurses who are trained to provide advice and assistance across a range of medical issues. Lifeline is available 24 hours a day, 365 days a year with no limit on the number of times you can call the service. All calls are strictly confidential and follow the nurses' UK Central Code of Professional Conduct.

By calling Lifeline you get access to:

- A Nurse Adviser on call 24 hours a day for medical advice and assessment.
- Medical advice from a Doctor via a telephone appointment service at a time convenient to you.
- Direction and advice on other medical services and out of hours claims information.

For advice about care options call GraceCare on 0800 137669

This service gives CS Healthcare members access to advice about choice of convalescent care, respite care, help at home or long-term residential care, should the need arise. The service is available to both the member and the member's family. By calling 0800 137669 you will be able to talk directly to Grace Consulting, who are experts in delivering independent advice about care options

of all kinds for elderly people and those requiring care as a result of injury or long-term illness.

GraceCare Guidance freephone 0800 137669
Email: customerservices@graceconsulting.co.uk
Web address: www.grace-care.com

Member responsibilities

As a member of CS Healthcare we request that you accept the following responsibilities:

Application for membership If you give false or misleading information (whether innocently or fraudulently) on application for health insurance cover; and this information would have affected the decision to insure you, the cover will end, and the Society will not pay any benefit to you.

Keeping the Society informed You must keep the Society informed about any changes to the original information that you provided to us. This includes but is not restricted to: change of address, change of name or circumstances.

Premium payments You must make sure that premium payments for the policy are paid on time and at the agreed amount for all those insured under your policy. If premiums exceed their due date by 90 days, the Society will automatically cancel your policy and all claim entitlements will cease.

You should be aware that if there are premium arrears on a policy, benefit will not be payable until the arrears have been settled in full.

Claims You must seek pre-authorisation and confirmation of cover before proceeding with treatment. For information about our claims procedure and guidelines please refer to the 'How to Claim for Health Insurance' section and 'How to Claim under the Cash Benefits option' within this Policy Document. Failure to pre-authorise a claim may lead to non-payment.

Please be aware, if you make a claim for symptoms that initially occur within the first year of membership or in the first three months for

Continued Personal Medical Exclusion policies, we will ask you to provide a copy of the GP referral letter for assessment of your claim.

*Calls to our Membership Services Team and Claims Helpline may be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

General Terms and Conditions

This policy is only available to you if you are a permanent resident in the United Kingdom and registered with an NHS GP.

When dealing with the Society you act on behalf of every dependant included on your policy.

Your address will be used for all correspondence in respect of your dependants covered under the policy unless otherwise agreed by the Society. You must therefore advise us immediately of any change of address.

The Society is guided by its not-for-profit status – as a friendly society we aim to provide a professional and personal service to our members. The Society may amend policy terms and conditions, including, but without limiting the foregoing, changing the benefits provided, for the following reasons:

- to enable the Society to meet its general legal and regulatory responsibilities;
- to allow the Society to respond to changes in the general law or regulation or to decisions of the Financial Ombudsman Service;
- to reflect legitimate cost increases or reductions associated with providing cover.

The Society will give members one month's notice of any such change by writing to them at their last known address according to the Society's records.

The Society reserves the right to:

- cancel this policy on non-payment of any premium or any other sum payable by the member under the terms of this policy;
- cancel this policy or terminate or change a member's cover if the member has:
 - misled the Society by misstatement or concealment, knowingly or otherwise;
 - assisted or concealed any attempt by any third party to defraud the Society;
 - otherwise failed to observe the terms and conditions of this Policy or the Memorandum of Association and Rules.

The membership agreement is governed by and is subject to the law of England and Wales.

Invalid benefit payments

If you break any of the terms of membership or make, or attempt to make, any dishonest or

reckless application or claim the Society shall be entitled to:

- refuse to pay any benefit
- cancel the membership immediately.

If the Society makes any payments to you as a result of fraud, recklessness or negligence the following actions may take place:

- your membership will be cancelled immediately
- the Society may demand that any benefits paid to you are reimbursed to the Society
- the Society may take legal action against you for the return of such monies paid out to you in benefit. It may be demanded that you reimburse the Society for any investigation costs incurred.

your choice health insurance - summary

your choice offers a flexible choice of cover so you can create your own package of health protection. Choose from four cover options to meet your needs for treatment and care received in the United Kingdom.

Essential: this compulsory part of your health insurance gives you comprehensive cover for treatment and care for eligible conditions (please refer to the 'Essential-schedule of benefits' section within this Policy Document for details) and undiagnosed symptoms. Essential gives you access to in-patient and day-patient care for surgery and medical admissions, out-patient surgical procedures, including all related hospital costs and consultants fees and specialised scans like CT & MRI scans. In addition to these benefits there is a 90 day period of necessary aftercare available which provides cover for post-operative consultations, investigations, tests and physiotherapy. If required, there is also cover for nursing at home or convalescence and private road ambulance fees. NHS cash allowance is available should you opt to have treatment in an acute NHS general hospital. See the 'Essential-schedule of benefits' within this Policy Document for full details.

Additional cover options:

Expert Diagnostics: this option gives you quick access for out-patient investigations and consultations for an acute illness or injury. You will have cover for consultations with a registered Consultant, investigations including blood tests, ultrasound scans and x-rays, therapeutic injections, dressings and wound care. Dietary advice under the supervision of your Consultant for treatment of a medical condition and up to £1000 benefit for out-patient psychiatric consultation and counselling

is also covered. See the 'Expert Diagnostics-schedule of benefits' section within this Policy Document for full details.

Therapy & Care: this option gives you fast access to a therapist, or other recognised practitioners for out-patient therapy and care following hospital admissions either newly diagnosed or following your 90 day necessary aftercare period available under Essential. You also have cover for physiotherapy, osteopathy, chiropractics, and the complementary therapies of homeopathy and acupuncture. A home help and appliances benefit is also available following your discharge from hospital. See the 'Therapy & Care-schedule of benefits' section within this Policy Document for full details.

Heart & Cancer: this option gives you access to in-patient and day-patient care for heart and/or cancer surgical and medical admissions, out-patient surgical procedures, including all related hospital costs, Consultant's fees, specialised scans such as, CT & MRI and investigations and physiotherapy for heart and cancer. For cancer conditions a period of necessary aftercare is available (including diagnostics, specialist scans, investigations and physiotherapy) for 5 years from the date of actual diagnosis. For heart conditions a period of necessary aftercare is also available including diagnostics, specialist scans and investigations and supportive care for 1 year from the date of admission for each acute heart condition. In addition there is also the benefit of the Your Care Package (if treatment is taken as a NHS patient) and NHS cash allowance. See the 'Heart & Cancer-schedule of benefits' within this Policy Document for full details.

Cash Benefits: this option gives you cash reimbursement up to agreed limits, for visits to the dentist, hygienist, for prescription contact lenses, and towards a full Health Screening. See the 'Cash Benefit-schedule of benefits' within this Policy Document for full details.

Hospital lists:

In addition to the above options, you have a choice of two hospital lists: Partnership and Extended.

Voluntary excess or co-payment:

You also have the option to reduce your premium payments by taking a voluntary excess or co-payment. Any reduction in policy premium in lieu of an excess or co-payment option is not applied to the Therapy & Care and Cash Benefits options.

Essential – schedule of benefits (D1)

BENEFIT	COVER	NOTES
Hospital care for in-patient, day-patient treatment and out-patient surgery for pre-authorized treatment that takes place in any hospital from your chosen hospital list		
Specialised scans	Covered*	You are covered for CT, MRI, PET, DAT, MIBG, Myelogram, Thallium and Perfusion/Ventilation scans.
Out-patient surgery and related charges	Covered*	Pre-authorized out-patient surgical procedures performed in an out-patient theatre, which are not performed as part of a Consultation in a consulting or treatment room.
Pre-operative tests to assess your fitness for surgery	Covered*	For up to 2 weeks prior to an authorised hospital admission to cover blood and urine tests, chest X-ray, ECG and assessment with an anaesthetist if required.
Post-operative consultations, investigations, tests and physiotherapy	Covered*	As a part of necessary aftercare within 90 days immediately following a planned pre-authorized private hospital admission.
Surgical admissions and related hospital charges	Covered*	Where you require surgery (including endoscopic procedures) cover will apply according to the average length of stay (for your surgical procedure) either as a day-patient or in-patient.
Medical admissions and related services	Covered*	Where a stay as either a day-patient or in-patient is required for either diagnostic reasons or to treat and stabilise an acute condition by medical and by non-surgical means.
Consultant/Specialist fees	As per the CS Healthcare Fee Schedule	All Consultant/Specialist fees will be paid for medical, consultant, physician supervisions according to the rates of the CS Healthcare Fee Schedule. Please refer to the medical fees section of our website www.cshealthcare.co.uk or call our Claims Helpline on 020 8410 0440 for full details.
Surgeon and Anaesthetist fees	As per the CS Healthcare Fee Schedule	All Surgeon and Anaesthetist fees will be paid according to the rates of the CS Healthcare Fee Schedule. Please refer to 'Surgeon and Anaesthetist Fees' section within the Policy Document and the medical fees section of our website www.cshealthcare.co.uk or call our Claims Helpline on 020 8410 0440 for full details.
Private road ambulance	Up to £250 per person per policy year	Where required out of medical necessity after hospitalisation.
Nursing at home or convalescence benefit	Up to 14 days each admission	Immediately following surgery after hospital admission either as a NHS or private patient under the specific direction of a Consultant/Specialist.
Parent accommodation	Covered*	For one or both insured parents staying with an insured child up to age of 16.

BENEFIT	COVER	NOTES
NHS cash allowance	£150 each day/night after admission to a UK NHS acute general hospital	Up to 28 days per person per policy year for eligible claims under this option.
Additional features		
Your Care Package	Covered*	Available to those undergoing NHS care in lieu of private treatment - a tailor made care package aimed at giving additional support while having treatment.
Out of band hospital benefit	Covered*	When using a hospital not included in our Directory of Hospitals, or included in your level of cover, we will pay a sum equivalent to that for a hospital on the list.
Lifeline	24 hour availability 365 days a year	Health advice line with Doctor call back service.
GraceCare	9am - 5.30pm Monday to Friday	Advice line to help choice of convalescent care, respite care, help at home or long-term residential care, should the need arise.
Voluntary excess options	£100, £300, £500, £1000	Voluntary excess chosen will only apply to Essential cover, Expert Diagnostics and Heart & Cancer. Please refer to the 'Voluntary Excess and Co-payment options' section within the Policy Document for further details.
Co-payment option	15% of claims up to £1500 per person per policy year	The co-payment option will only apply to Essential cover, Expert Diagnostics and Heart & Cancer. Please refer to the 'Voluntary Excess and co-payment options' section within the Policy Document for further details.

***Please note: by 'Covered' we mean that all cost must be necessary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received.**

IMPORTANT NOTES:

1. Please note, **we will not pay** overnight hospital accommodation and related charges which are related to treatment that would normally be carried out as a day-patient or out-patient; for the purpose of convalescence or rehabilitation; for therapies including complementary; for early admission or late discharge or for the purpose of personal need and/or social arrangements not associated with an acute medical need or the expected length of stay which is displayed on your Pre-authorisation Certificate of cover.

2. Heart and cancer conditions are not covered by Essential. If you are having symptoms investigated which are diagnosed as a heart or cancer condition, cover will cease under this option once the necessary aftercare period has passed. Heart conditions that arise as a complication alongside another eligible condition will be covered. Please see the 'Heart & Cancer-schedule of benefits' within this Policy Document for clarification of what is exactly covered.

3. You are not covered for emergency admissions that require life saving treatment, including immediate life saving surgery or critical care. Urgent admissions where a patient is admitted to a general ward may be covered provided you no longer require critical care or special monitoring of vital signs.

For full details of what we **will not pay**: please refer to the 'General Policy Exclusions' and 'Specific Treatment Exclusions and Advice' sections in this Policy Document.

4. You will be covered after you have been discharged for a **90 day period of necessary aftercare**. This will include cover up to a maximum of 3 post-operative or follow-up consultations, 6 sessions of physiotherapy, where related directly to your surgery or medical admission to check your progress or treat any complications. Wound care, dressings and small procedures will also be covered when they are a direct consequence of your surgery or medical admission.

5. Where diagnostic endoscopies, biopsies or similar procedures are performed we will cover one follow-up consultation to collect the results. Ongoing consultations for diagnostic purposes or to plan a further procedure are not covered. Where genuine post-operative complications have occurred, or stabilisation of a medical condition is still being sought within the 90 day necessary aftercare period, we will give further consideration to cover on submission of a treatment plan from either the Consultant/Specialist.

6. NHS cash allowance is payable for admissions into care in an acute general hospital for treatment of acute conditions, only where no transfer or admission from or to private care takes place for the same or related medical or surgical episode and any related complications; this excludes transfers into rehabilitation facilities, long-stay or psychiatric hospitals.

Expert Diagnostics option – schedule of benefits (D2)

BENEFIT	COVER	NOTES
Out-patient benefits		
Consultations with a Consultant/Specialist	Covered*	On referral from your GP, Optician or Dentist or another Consultant/Specialist. You are also covered if you wish to seek a second opinion or a referral to another Consultant/Specialist if necessary.
Investigations and tests: Including blood tests, ECG, EEG, ultrasound scan, X-rays and related tests	Covered*	As part of consultant supervised care or on GP referral.
Treatment room procedures such as excision of lesions, small biopsies and cryotherapy and any related pathology. Therapeutic injections for pain relief or to treat specific symptoms Dressings and wound care Application of plaster or fibre casts	Covered*	As part of consultant supervised treatment.
Dietician Audiology Optometry	Covered*	Under the supervision of your Consultant/Specialist for treatment of an eligible medical condition.
Psychiatric consultations and counselling	Up to £1000 per person per policy year	On referral from your GP or another Consultant/Specialist to a Consultant Psychiatrist or recognised Counsellor.

***Please note: by 'Covered' we mean that all cost must be necessary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received.**

IMPORTANT NOTES:

Heart and Cancer conditions are not covered by the Expert Diagnostics option, if you have symptoms investigated which are then diagnosed as a heart or cancer condition, no further cover will be given under Expert Diagnostics.

For full details of what we **will not pay**: please refer to the 'General Policy Exclusions' and 'Specific Treatment Exclusions and Advice' sections in this Policy Document.

Therapy & Care option – schedule of benefits (D3)

BENEFIT	COVER	NOTES
Manipulative out-patient benefits		
Physiotherapy	Covered*	On either referral from your General Practitioner or under supervision from a Consultant/Specialist.
Osteopathy		We will initially pre-authorise 2 sessions in the first instance, if more treatment is required we will expect the Therapist to supply a treatment plan on request so we can confirm what further cover is available.
Chiropractic treatment		
Sports therapy		
Complementary out-patient benefits		
Acupuncture	Covered*	On either referral from your General Practitioner or under supervision from a Consultant/Specialist.
Homeopathy		We will pre-authorise 6 sessions in the first instance, if more treatment is required we will expect the Therapist to supply a treatment plan on request so we can confirm what further cover is available. Excludes the costs of medicines or remedies.
Treatment and recovery benefits		
Chiropody and Podiatry	Up to £400 per person per policy year	To treat in-growing toenails, verruca's and for biomechanical assessment and orthotic's.
Speech therapy	Covered*	As part of medical treatment.
Occupational therapy	Covered*	Following an acute illness, or following an NHS in-patient admission to assess your needs or your activities of daily living or for a pre agreed course of therapy to aid recovery.
Appliances/aids following in-patient admission	Up to £400 per person per policy year	For example, raised toilet seats, grab rails, walking sticks, zimmer type frames, bath stools and bath aids, chair raises or special chairs. Available when recommended by a Consultant or Therapist.
Home help	Up to 14 days each admission	Immediately following a hospital admission, under the specific direction of the Consultant/Specialist and carried out by a registered home help or carer.
*Please note: By 'Covered' we mean that all cost must be necessary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received.		

Please note: no excess or co-payment is applicable to this option.

For full details of what we **will not pay**: please refer to the 'General Policy Exclusions' and 'Specific Treatment Exclusions and Advice' sections in this Policy Document.

Heart & Cancer option – schedule of benefits (D4)

HEART BENEFIT	COVER	NOTES
In-patient, day-patient and out-patient treatment		
Surgical admission: for Heart (cardiac) surgery including implanted prosthesis, including valves and related hospital charges	Covered*	<p>This covers both open & closed surgical procedures.</p> <p>Covered for accommodation, theatre costs and all related investigations and medical costs like physiotherapy and dietician.</p> <p>All Surgeon and Anaesthetist fees will be paid according to the rates of the CS Healthcare Fee Schedule. Please refer to the medical fees section of our website www.cshealthcare.co.uk or call our Claims Helpline on 020 8410 0440 for full details.</p>
Non-surgical admission: Heart (cardiac) medical care including related hospital charges	Covered*	<p>Covered for accommodation, theatre and all related investigations & medical cost and Consultant fees.</p> <p>Where a stay is either for a day-patient or overnight patient is required for either diagnostic reasons or to treat and stabilise an acute condition by medical and by non-surgical means.</p>
Nursing at home or convalescence benefit or Home help	Up to 14 days each admission	Immediately following surgery or a non-surgical admission on discharge from hospital under the specific direction of a Consultant/Specialist, either as an NHS or private patient.
Heart (cardiac) necessary aftercare; including diagnostics, specialist scans & investigations, physiotherapy/rehabilitation and supportive care including care of a registered Dietician within 1 year from the date of admission for each acute condition treated or Acute episodes of a previously covered condition, to investigate and stabilise the symptoms in the short term.	Covered*	<p>Following a privately funded hospital admission or an acute recurrence of a condition pre-authorised by CS Healthcare, you are also covered for consultations & investigations including; CT, MRI, PET, DAT, MIBG, Myelogram, Thallium and Perfusion/ Ventilation scans.</p> <p>Covered for procedures such as angiograms, transoesophageal echocardiograms, electrophysiological studies, cardioversion and pacemaker insertion and checks.</p> <p>If a new and separate heart condition requires admission as described above and this occurs during an already pre-authorised 12 month follow-up period, the period of necessary aftercare will be extended from the date of the new admission date accordingly.</p>
CANCER BENEFIT	COVER	NOTES
In-patient, day-patient and out-patient treatment		
Cancer related surgery, including implanted prosthesis, endoscopies and hospital charges	Covered*	<p>Covered for accommodation, theatre costs and all related investigations and medical costs including physiotherapy and dietician.</p> <p>Surgeon and Anaesthetist fees will be paid according to the rates of the CS Healthcare Fee Schedule. Please refer to the medical fees section of our website www.cshealthcare.co.uk or call our Claims Helpline on 020 8410 0440 for full details.</p>

CANCER BENEFIT	COVER	NOTES
Cancer treatment and medical admissions; including radiotherapy and chemotherapy, and related treatments such as monoclonal antibodies and hormone therapies	Covered*	<p>Covered for accommodation, theatre and Consultant/Specialist fees.</p> <p>Covered where a stay as either a day-patient or overnight patient is required for either diagnostic reasons or to treat and stabilise an acute condition by medical and by non-surgical means.</p> <p>Covered where chemotherapy, and other drugs therapies are given at home.</p> <p>Covered for Radiotherapy including brachytherapy & implants and chemotherapy other drug therapies for the treatment of cancers (malignant) disease including brain tumours.</p> <p>The care of secondary (metastatic spread) and supportive care (palliative care) including bone strengthening drugs, anti tumour growth treatments and hormone therapies.</p>
Necessary aftercare per Cancer condition, including consultations, diagnostics, specialists scans and investigations and physiotherapy for 5 years following the initial diagnosis	Covered*	<p>Covered for consultations and related investigations including cover for CT, MRI, PET, DAT, MIBG, Myelogram, Thallium and Perfusion/Ventilation scans.</p> <p>If secondary disease occurs outside the 5 year monitoring period a maximum of 3 consultations will be covered following completion of radiotherapy and chemotherapy.</p>
Counselling Dietician Complementary Therapies	Covered*	Covered for counselling, dietary advice and complementary therapy under direction of your Consultant/Specialist or treating hospital.
Nursing at home or convalescence benefit	Up to 14 days each admission	Immediately following surgery or a non-surgical admission on discharge from hospital under the specific direction of a Consultant/Specialist, either as an NHS or private patient.
Additional benefits		
Private road ambulance	Up to £250 per person per policy year	Where required out of medical necessity after hospitalisation.
NHS cash allowance	£150 each day/night after admission to a UK NHS acute general hospital	Up to 28 days per person per policy year for eligible claims under this option.
Additional features		
Your Care Package	Covered*	Available to those undergoing NHS care in lieu of private treatment - a tailor made care package aimed at giving additional support while having cancer or heart treatment. Or requesting consideration for cancer drugs to supplement NHS care.

CANCER BENEFIT	COVER	NOTES
Hospice care donation	Up to £400 per person per policy year	On referral from your Consultant/Specialist or medical practitioner we will pay a donation to the Hospice that you are placed with.
Out of band hospital benefit	Covered*	When using a hospital not included in our Directory of Hospitals or included in your level of cover, we will pay a sum equivalent to that for a hospital on the list.

***Please note: by 'Covered' we mean that all cost must be necessary and reasonably incurred and benefit will be paid in accordance with the customary fees and charges for treatment received.**

IMPORTANT NOTES:

1. Please note, **we will not pay** overnight hospital accommodation and related charges which are related to treatment that would normally be carried out as a day-patient or out-patient; for the purpose of convalescence or rehabilitation; for therapies including complementary; for early admission or late discharge or for the purpose of personal need and/or social arrangements not associated with an acute medical need or the expected length of stay which is displayed on your Pre-authorisation Certificate of cover.

2. You are not covered for emergency admissions that require life saving treatment, including immediate life saving surgery or critical care. Urgent admissions where a patient is admitted to a general ward may be covered provided you no longer require critical care or special monitoring of vital signs.

3. For full details of what we **will not pay**: please refer to 'General Policy Exclusions' and 'Specific Treatment Exclusions and Advice' sections in this Policy Document.

However it is important to note that where some out-patient prescription drugs like hormone therapies are freely available on NHS prescription **we do not cover** these routinely- please refer to Specific Treatment Exclusion 'S8' in this Policy Document.

4. You will be covered for heart and cancer treatment, following a confirmed diagnosis of one of these conditions. When considering 'Heart & Cancer' cover please refer to Specific Treatment 'S1' in this Policy Document for details as to what is covered within Unlicensed / Experimental treatment.

5. By confirmed diagnosis we mean: that you have had symptoms investigated and as a result it has been confirmed that you have a heart (cardiac) or cancer (oncology) condition. Some elements of your diagnostics may have been covered by Essential or the Expert Diagnostics option (if chosen) otherwise the diagnostic care will have been either funded by yourself or as an NHS patient.

6. By heart we mean: any illness, disease or congenital defect of the heart, including the myocardium (heart muscle), pericardium and the endocardium, heart valves, conducting system, blood vessels and great blood vessels including the aorta, pulmonary artery and veins, and the vena cava. For example:

- Coronary Artery Disease } Angina, Myocardial Infarction (heart attack)
- Ischaemic Heart Disease }
- Major Vessel Disease – Aortic conditions affecting your veins or arteries (with the exception of varicose veins, vascular surgery for limbs and lymphatic system, these are covered under Essential)
- Valve Disease requiring replacement – of the Aortic, Bicuspid, Tricuspid (mitral), Pulmonary valves
- Aortic Aneurysm
- Conduction/Rhythm Disorders - like Atrial Fibrillation, Syncope, Bradycardia
- Cardiac Failure
- Cardiomyopathy
- Peri-Carditis/Endocarditis

7. By cancer we mean: any type of brain tumour and neoplastic disease. For example

- Breast Cancer
- Colon Cancer
- Oral Cancers
- Skin Cancers – Basal Cell Carcinoma – Malignant Melanoma
- Prostate Cancers
- Lymphomas - Hodgkin's and Non-Hodgkin's Lymphomas
- Blood Cancers Myeloma and Leukaemia
- Bone Cancers

8. NHS cash allowance is payable for admissions into care in an acute general hospital for treatment of acute conditions, only where no transfer or admission from or to private care takes place for the same or related medical or surgical episode and any related complications; this excludes transfers into rehabilitation facilities, long-stay or psychiatric hospitals.

Cash Benefits option – schedule of benefits (D5)

CASH BENEFITS	COVER	NOTES
Out-patient benefits		
Benefit amounts are per person per policy year per type of cover	Dental treatment Check-ups, orthodontic, periodontal and hygienist treatment.	Benefit is not payable in respect of treatment under dental capitation schemes and dental insurance. This benefit does not exclude any dental related condition that was in existence prior to the start of the policy i.e. pre-existing condition.
	Optical treatment Eye examinations, prescription glasses or sunglasses and prescription contact lenses.	No benefit is payable towards the cost of the following – <ul style="list-style-type: none"> ■ Repairs to glasses. ■ Eye laser surgery. ■ Frames without lenses. ■ Contact lenses used for cosmetic purposes. ■ Contact lens solution. ■ Non-prescription glasses or sunglasses. This benefit does not exclude any eye related condition that was in existence prior to the start of the policy i.e. pre-existing condition.
Level 1: Up to £50		
Level 2: Up to £100		
Level 3: Up to £150	Health Screening Health Screening to assess the state of your general health to include: Wellwoman & Wellman Screening, Breast Cancer Screening, Osteoporosis Screening, Bowel Cancer Screening, Cervical Screening, Executive check-ups.	<ul style="list-style-type: none"> ■ Any claim for Health Screening must have been carried out by a recognised Health Screening Centre under the supervision of a registered Physician. ■ CS Healthcare will not pay any benefit towards Health Screenings other than the ones listed opposite. ■ CS Healthcare will not pay benefit for a Health Screening undertaken for the purpose of the member's employment, legal or insurance reasons. ■ CS Healthcare will not pay Health Screening benefit for any child dependant under the age of 25 years. ■ CS Healthcare will not pay benefit for missed appointment fees.
Level 4: Up to £200		

IMPORTANT NOTES:

In order to claim benefit for Dental and Optical treatment there is a qualifying period of 3 months continual Cash Benefits membership. During this qualifying period, no benefit is payable.

In order to claim Health Screening benefit there is a qualifying period of 12 months continual Cash Benefits membership. During this qualifying period, no benefit is payable.

The Your Care Package

The Society, at its discretion, may offer alternative benefits under Essential and Heart & Cancer termed the Your Care Package, for those members opting to have NHS care in lieu of private treatment.

Your policy covers you for private treatment (subject to the terms and conditions of your policy). However, if you choose to have your treatment free of charge on the NHS, CS Healthcare can put your benefit to an alternate use to assist your individual needs. This could include child care, aids to assist you around the house, pet care and travel allowance.

Once your condition has been diagnosed by your Consultant/ Specialist and you have discussed the treatment options available to you, please contact our Managed Care Team on 020 8410 0440.

If you opt for NHS treatment, we will draw up an agreement with you confirming the care which will be covered by CS Healthcare.

You can request a factsheet explaining the Your Care Package by calling the Claims Helpline on 020 8410 0440.

Please note that not all cases are suitable for the Your Care Package and we would only pay benefits in lieu of any benefits that you may be entitled to under your chosen level of cover.

How to Claim for Health Insurance

If your claim is pregnancy related or for dental treatment (excluding reimbursement via the Cash Benefits option) please ask to speak to the Managed Care Team on 020 8410 0440.

Please see below for the claims process for your chosen method of Underwriting. If you are unsure as to which process applies to you or which underwriting method you have selected please refer to your Registration Certificate or alternatively please contact the Membership Services Team on 020 8410 0400.

Claims process for:

- **Moratorium (MOR) or Continued Moratorium (CM) members.**
- **Continued Personal Medical Exclusions (CPME) members for symptoms that first occur in the first 3 months of membership.**
- **Full Medical Underwriting (FMU) members for symptoms that first occur in the first 12 months of membership.**

Step 1

Visit your GP. If your GP refers you for tests or treatment and you wish to go private please ask your GP for a copy of the referral letter and then call the Claims Helpline on 020 8410 0440.

Please ensure you have the following details:

- Date symptoms started
- Date you first visited your GP regarding this condition
- Your policy number

Step 2

The referral letter needs to be sent to CS Healthcare so that we can assess the details of your condition and whether your claim is valid.

Step 3

On assessment of a valid claim we will send a Claim Form for completion by your Consultant/Specialist and will preauthorise your initial treatment.

Step 4

The Claim Form needs to be returned to CS Healthcare in support of the treatment proposed (including day-patient or in-patient treatment).

A pre-authorization certificate will be sent to you as confirmation of cover.

Step 5

When we receive invoices for treatment we will settle them directly with your provider. If you have a co-payment or excess on your policy we will advise what you need to pay.

And Finally...

If you require further treatment, please call us again.

Please Note:

On occasion we may need further information to confirm that this claim does not relate to a pre-existing condition. If this is the case it may be necessary to speak to a member of our underwriting team who may request that you send us copies of medical reports or documentation about the treatment you are claiming for.

How to Claim for Health Insurance - continued

Claims process for:

- **Continued Personal Medical Exclusions (CPME) members for symptoms that first occur AFTER the first 3 months of membership.**
- **Full Medical Underwriting (FMU) members for symptoms that first occur AFTER the first 12 months of membership.**

Step 1

Visit your GP. If your GP refers you for tests or treatment and you wish to go private call the Claims Helpline on 020 8410 0440.

Please ensure you have the following details:

- Date symptoms started
- Date you first visited your GP regarding this condition,
- Your policy number

Step 2

One of our Claims Advisers will take details of your claim and talk you through your cover, what you can claim, and what happens next.

Please refer to your Registration Certificate which confirms your level of cover.

Step 3

After we have confirmed cover over the telephone we will send a Claim Form for completion by your Consultant Specialist/Therapist/GP (as advised and detailed on the form). The Claim Form needs to be returned to CS Healthcare in support of the treatment proposed (including day-patient or in-patient treatment).

A pre-authorisation certificate will be sent to you as confirmation of cover.

Step 4

When we receive invoices for treatment we will settle them directly with your provider. If you have a co-payment or excess on your policy we will advise what you need to pay.

And finally...

If you require further treatment, please call us again.

Please Note:

On occasion we may need further information to confirm that this claim does not relate to a pre-existing condition. If this is the case it may be necessary to speak to a member of our underwriting team who may request that you send us copies of medical reports or documentation about the treatment you are claiming for.

When you contact the Claims Helpline to make a claim on your policy we will ask you to provide the following information:

- your policy number
- what condition the claimant is suffering from
- has the claimant claimed for this condition previously
- your claim number (only if you have claimed for this condition previously)
- when the symptoms first began
- the date on which the GP was first seen for this condition
- has the GP made a referral to a Consultant, further investigations or for treatment
- the name of the Consultant to which a referral has been made.

We will then talk you through the cover available under your policy, and will guide you on what you need to do next.

What happens if you have more than one insurance policy and/or a cash plan?

You must tell the Society if you think any of the cost of your claims can be claimed from any other insurance policy that you hold, if so then:

- we will only pay our proper share of the claim
- if we settle your claim first, we will contact the other insurer for their share.

If you hold a cash plan with us or another insurer, and are claiming for a medical expense covered under both your Private Health Insurance policy and a cash plan:

- you should claim the expense under your cash plan policy first
- we will pay any eligible balance due under your Private Health Insurance policy.

We shall not be liable to pay or contribute more than our proportionate share between the insuring parties for any benefits covered under several plans.

What happens if you are also claiming against a third party?

If you are claiming against a third party, for compensation as a result of a Road Traffic Accident or other claim, and have claimed medical expenses from us:

- you must tell us
- we will write to your Solicitor giving details of the medical expenses for which you have claimed, asking them to include the cost of these expenses in your claim with the third party, if appropriate

- if your case is successful and compensation is paid (whether in full or part settlement) you will need to pay our outlay to us. In the event of part-settlement you will need to pay us the percentage of medical expenses costs recovered
- you (or your Solicitor) must keep us informed about the progress and outcome of any claim.

Settlement of invoices

CS Healthcare will settle its share of treatment costs on your behalf. We will inform you in writing of the payment made and any outstanding amounts for you to pay. Any balance due will normally be in respect of a co-payment, an excess, or shortfall on an invoice.

Payment of accounts will only be settled with the provider on acceptance of a valid claim and receipt of a fully completed Claim Form.

Most hospitals will submit accounts to CS Healthcare directly; however, you may receive accounts from your Specialist or other service provider. Please forward all such accounts to us (ensuring that they are the originals) and we will settle them directly in accordance with the terms and conditions of your policy. It is recommended that you keep a copy of any account sent to you or your own records.

In the event that you are required to pay at the time of your treatment, you should send the receipted invoice to us and we will reimburse you accordingly.

How to Claim under the Cash Benefits option

To receive any of the Dental, Optical and Health Screening benefits you will need to complete a Claim Form that we will provide. To request a Claim Form, please call 020 8410 0440.

When making a claim, you will need to send us the completed Claim Form and attach your original receipts. In addition if you are claiming Health Screening benefit you will need to get the registered Physician to stamp your Claim Form.

How we deal with Chronic and Acute conditions

What is a chronic condition?

The **your choice** policy is designed to provide cover for the treatment of acute conditions. By this we mean those conditions, diseases or illnesses that respond to short term treatment with the aim of returning you to the state of health you were in before suffering the disease, illness or injury. These policies do not cover treatment of a chronic or long-term condition. Your policy defines a chronic medical condition as: a disease, illness or injury which has one

or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and/or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back.

What does this mean in practice?

We provide benefit for the initial consultation and investigations, and up to three further consultations to allow the medical condition to become stable.

If it becomes evident that the member requires further treatment or the condition is proving hard to stabilise, we will contact the treating Consultant and request a medical report to ascertain exactly what we can cover and when transfer to NHS care will be required. When the period of pre-authorised treatment is finished the claim for the condition will be closed and you will be notified of this in writing.

If surgery is required to treat a chronic condition, this would be covered (subject to pre-authorisation) under the appropriate surgical heading as described in the 'Specific Treatment Exclusions and Advice' section. Again, a short period of follow up consultations will be covered (only available if you are covered under the Expert Diagnostics option).

What if the condition gets worse?

We may review the claim and provide further benefit if an acute episode of the diagnosed chronic condition is confirmed. Some chronic conditions have acute flare ups, sometimes referred to as 'acute on chronic' where the condition worsens for a short period of time. Where an admission to hospital is required to stabilise such an event we can consider a period of Consultant led care only after pre-authorisation has been sought and subject to the policy limits described within each of the options (see all of the schedule of benefits within this Policy Document for details). Following identification of an acute episode, we will liaise with the Consultant and the hospital and obtain a treatment plan. Following an acute episode we will allow two to three follow up consultations if benefit is available (only under Expert Diagnostics option).

Examples of chronic conditions are:

- Osteoarthritis
- Neck and Back pain
- Osteoporosis
- Macular degeneration
- Glaucoma
- Hypertension/Angina

- Diabetes Mellitus
- Blood clotting disorder
- Heart valve disease

For details on chronic and long-term condition exclusions please refer to 'Specific Treatment Exclusions and Advice' rule S2 within this Policy Document.

Typical examples of chronic conditions

EXAMPLE 1 – ANGINA & HEART DISEASE:

Alan has been with CS Healthcare for many years. He develops chest pain and is referred by his GP to a Specialist. He has a number of investigations and is diagnosed as suffering from Angina. Alan is placed on medication to control his symptoms.

If you are covered under the Expert Diagnostic option we will cover the initial consultation and diagnostic tests, if you required a specialist scan or diagnostic surgery (including endoscopy) this would be covered under Essential. However, once a diagnosis of Angina has been confirmed the Heart & Cancer option would be required to cover any further care, but once the condition is controlled by medication the monitoring of the condition would not be covered.

Two years later, Alan's chest pain recurs more severely and his specialist recommends that he has a heart by-pass operation.

Under the Heart & Cancer option we will cover the procedure and a short period of post-operative care, as an acute phase. Once the condition is stable again cover would be withdrawn under the chronic heading.

Emergency admissions to hospital are not covered as the NHS would cover any emergencies. The Heart & Cancer option would cover any admissions, subject to pre-authorisation, to a general ward setting. No admission directly to ITU or HDU can be covered, we would cover this as an acute phase with limited out-patient follow-up.

EXAMPLE 2 – ASTHMA:

Eve has been with CS Healthcare for five years when she develops breathing difficulties. Her GP refers her to a specialist who arranges for a number of tests. These reveal that Eve has asthma. Her Specialist puts her on medication and recommends a follow up consultation in three months to see if her condition has improved. At that consultation Eve states her breathing has been much better. So the specialist suggests she has check-ups every four months.

Under Expert Diagnostics we would cover the initial consultations and investigations needed to stabilise the condition. Expert Diagnostics will not cover any ongoing consultations for a Chronic condition such as asthma.

Eighteen months later, Eve has a bad asthma attack.

Emergency admissions to hospital are not covered as the NHS would cover any emergencies. Essential or Heart & Cancer would cover any admissions subject to pre-authorisation to a general ward setting, however, admission directly to a critical care setting like ITU or HDU or emergency life saving surgery cannot be covered. But if the admission is to a general ward setting we would cover this as an acute phase with a limited period of out-patient follow-up.

EXAMPLE 3 – HIP PAIN:

Bob has been with CS Healthcare for three years when he develops hip pain. His GP refers him to an Osteopath who treats him every other day for two weeks and then recommends that he return once a month for additional treatment to prevent a recurrence of his original symptoms.

If you are covered under the Therapy & Care option we will only cover the initial course of osteopathy treatment needed to stabilise the condition. We would not cover the monthly visits as this is maintenance of a long-term Chronic condition.

EXAMPLE 4 – DIABETES:

Deirdre has been with CS Healthcare for two years when she develops symptoms that indicate she may have diabetes. Her GP refers her to an endocrinology specialist who organises a series of investigations to confirm the diagnosis, and she then starts on oral medication to control the diabetes. After several months of regular consultations and some adjustments to the medication regime, the specialist confirms the condition is now well controlled and explains he would like to see her every four months to review the condition.

Expert Diagnostics will cover the initial consultations and investigations needed to stabilise the condition. However, Expert Diagnostics will not cover any ongoing consultations for a Chronic condition such as diabetes.

One year later, Deirdre’s diabetes becomes unstable and her GP arranges for her to go into hospital for treatment.

Emergency admissions to hospital are not covered as the NHS would cover any emergencies. Essential would cover any admissions subject to pre-authorisation to a general ward setting, however, admission directly to a critical care setting like ITU or HDU or emergency life saving surgery cannot be covered. We would cover an admission to a general ward setting as an acute phase with a limited period of out-patient follow up.

Please note that the above examples are based on the assumption that the individual has not been excluded for treatment relating to the medical conditions and are subject to the relevant policy terms and conditions being met.

Typical examples of cancer conditions

EXAMPLE 1

Beverley has been with CS Healthcare for five years when she is diagnosed with breast cancer. Following discussion with her specialist she decides to have the breast removed followed by breast reconstruction. Her specialist also recommends a course of radiotherapy and chemotherapy. In addition she is to have hormone therapy tablets for several years. Will her insurance cover this treatment plan and are there any limits to the cover?

Under the Heart & Cancer option Beverley would be covered for removal of her breast (mastectomy), and breast reconstruction either immediately, or within 2 years of the original surgery or on completion of the recommended radiotherapy & chemotherapy. If hormone therapy is recommended and available by GP prescription we would not cover the out-patient prescription unless the prescribed treatment was not available to her via her GP. As long as Beverley remained a CS Healthcare policy holder with the Heart & Cancer option we would cover the 5 year follow-up period for Consultations and diagnostic scan and other related investigations.

EXAMPLE 2

Cara has previously had breast cancer which was treated under her existing policy by lumpectomy, radiotherapy and chemotherapy. She now has a recurrence in her other breast and has decided to have a mastectomy, radiotherapy and chemotherapy. Will her insurance cover this and are there any limits to the cover?

Under the Heart & Cancer option Cara would be covered for this treatment of mastectomy, chemotherapy and radiotherapy - if recommended by her supervising Consultant. Depending upon the length of time that has passed since the original diagnosis of breast cancer and Cara remaining a CS Healthcare policy holder; we would continue to cover follow-up consultations under the original 5 year monitoring period which would also cover diagnostic scan and other related investigations. If Cara was outside the 5 year monitoring period we would cover 3 follow-up consultations on completion of the radiotherapy or chemotherapy. If treatment of acute symptoms still required supervision or treatment following the radiotherapy or chemotherapy, this would be covered subject to medical report and treatment plan being submitted from Cara's treating Consultant.

EXAMPLE 3

Monica, who was previously treated for breast cancer under her existing policy, has a recurrence which has unfortunately spread to other parts of the body. Her specialist has recommended the following treatment plan:

- **A course of six cycles of chemotherapy aimed at destroying cancer cells to be given over the next six months.**
- **Monthly infusions of a drug to help protect the bones against pain and fracture. This infusion is to be given for as long as it is working (hopefully years)**
- **Weekly infusions of a drug to suppress the growth of the cancer. These infusions are to be given for as long as they are working (hopefully years).**

Will her insurance cover this treatment plan and are there any limits to the cover?

Under the Heart & Cancer option Monica could have the six cycles of chemotherapy, along with 12 months of bone strengthening treatment, and infusions to suppress growth of the cancer. After 12 months an assessment of Monica's treatment plan would be undertaken with her supervising Consultant and where ongoing treatment was required indefinitely we would look to withdraw cover back under the care of the NHS if available as the your choice policy does not cover long-term monitoring or preventative treatment.

EXAMPLE 4

Sharon would like to be admitted to a Hospice for care aimed solely at relieving symptoms.

Will her insurance cover this and are there any limits to the cover?

Under the Heart & Cancer option Sharon would be able to use a privately funded Hospice. Where a Hospice does not charge for the care services a donation of £400 per policy year will be made directly to the Hospice.

Claim Terms and Conditions

The Society will only consider a claim if:

- you have contacted the Claims Helpline on 020 8410 0440 for pre-authorisation of your claim; and
- the claim is being made through Essential or any other chosen option that you have which is valid at the time of your claim; and
- the condition or policy upgrade does not have a personal exclusion listed against it or qualifies under the Moratorium terms of your policy (please refer to 'General Policy Exclusions' section rule G4); and
- the condition or treatment is not stated as a policy exclusion (please refer to 'General Policy Exclusions' and 'Specific Exclusions and Advice' rule S3 for details); and
- your policy is current at the time that you receive treatment and there are no contribution arrears on the/your policy. Benefit will not be payable until the arrears have been cleared even if pre-authorisation has been given; and
- you and your insured dependant's, GP, Optical or Dental Practitioner has made the referral for opinion or treatment; and
- a fully completed Claim Form, has been submitted to us prior to the commencement of treatment; and
- we have been given all additional information requested, for you or for your insured dependants, from either a GP or your treating Consultant or from any person who has provided any of the treatment which is the subject of the claim; and
- we receive original invoices, for treatment costs no later than one year from the date of treatment; and
- the claim is not fraudulent or reckless and the condition or symptoms for which you are claiming are not pre-existing whether you knowingly or mistakenly failed to disclose the information to us at the time of joining the Society (this includes occasions where we have pre-authorised a claim in good faith and it has later been brought to our attention that the subject of the claim was pre-existing or fraudulent); and
- all costs associated with the pre-authorised treatment are necessary and reasonably incurred, and that hospital costs are only incurred from a facility listed in your chosen part of the Directory of Hospitals, unless CS Healthcare has pre-authorised

an alternative hospital. All Consultant/Specialist Surgeon and Anaesthetist fees will be paid in full according to the rates of the CS Healthcare Fee Schedule (please refer to the medical fees section of our website www.cshealthcare.co.uk for full details or call the Claims Helpline on 020 8410 0440).

Surgeon and Anaesthetist Fees

Consultants/Specialists can legally charge a patient whatever they wish and while the majority will charge within our guidelines, a minority may not.

CS Healthcare will reimburse you the fees which we consider customary and reasonable, as per our Fee Schedule (please refer to the medical fees section of our website www.cshealthcare.co.uk for full details or call the Claims Helpline on 020 8410 0440).

The maximum amount of fees we expect to pay for a procedure will be clearly detailed on your Pre-Authorisation Certificate; you may wish to discuss this with your Consultant/Specialist prior to your surgery.

A Consultant/Specialist will consider the agreement to treat a person as a contract between himself and the patient, and if they are unwilling to bill according to our customary and reasonable fees this could result in you having a shortfall which the Consultant will consider your responsibility. In the event that your treatment is more complicated than the procedure described on your Claim Form, we can consider an enhanced fee on receipt of a supporting letter from your Consultant/Specialist.

A Surgeon's Fee will cover the cost of the surgical procedure according to the relevant Clinical Classification and Schedule of Development (CCSD) code and complexity of the procedure.

It will also cover the period of post-operative supervision according to the average expected length of stay associated to the procedure. If an admission goes over the expected length of stay for a reason of medical necessity a further daily fee will be considered on submission of a medical update.

Where a Surgeon administers local anaesthesia or IV sedation AC100 we will also pay an additional fee to the main procedure.

Second Consultant/Specialist: if out of medical necessity there is the need for a second Consultant/Specialist to assist during a procedure, please contact the Managed Care Team for assistance. Fees for a surgical assistant are not covered. If a second Consultant/Specialist is to be present during a theatre time to perform a separate procedure under the same anaesthetic then they will be reimbursed accordingly using the allocated CCSD code.

An Anaesthetist fee will cover the initial in-patient

anaesthetic assessment, the cost of the anaesthetic including care in a critical care unit and pain relief within the first 24 hours directly following surgery. Should anaesthetic supervision be required following the initial 24 hour care in a Critical Care Unit, a further two days it can be reimbursed for daily supervision.

Where it is necessary for an Anaesthetist to perform a pain relieving procedure in isolation (either outside the first post operative 24 hours or to treat an acute condition) they will be reimbursed in the same manner as we manage surgeons fees. Local anaesthesia or IV sedation (AC100) will be paid in addition to the main procedure.

Occasionally 'Standby' Fees are billed for Surgeons and Anaesthetists who may need to intervene in an event of an emergency. Where appropriate, these fees will be reimbursed according to the correct CCSD code.

Multiple Procedure Policy:

For a single procedure we will pay the 100% customary and reasonable Surgeon and Anaesthetist fees according to the required CCSD code and its recognised complexity.

If multiple procedures are carried out during one theatre admission, we will pay:

- primary procedure – up to 100% of the listed fee price.
- 2nd procedure – up to 50% in addition to the primary procedure.
- 3rd procedure – up to 25% in addition to the primary and second procedure.

For bilateral procedures not identified within a specific CCSD code we will pay 100% of the actual procedure plus an additional 66%.

Maximum permitted fee amounts are clearly detailed on the Pre-Authorisation Certificate issued as confirmation of your level of cover. For further advice or to clarify a level of fee reimbursement please contact the Claims Helpline – 020 8410 0440 alternatively you can use the CS Healthcare Fee Schedule available at www.cshealthcare.co.uk.

General Policy Exclusions

General Policy Exclusions describes particular terms which are excluded from your cover.

The Society will not cover

- G1** Any benefit for a **your choice** option you have not chosen and are currently not paying a premium for cover.
- G2** Any voluntary excess or co-payment shown on your Registration Certificate.

G3 Treatment and Medical costs: Any treatment in a or hospital not on our lists from the Extended list of the Directory of Hospitals when you have chosen the Partnership list.

The only time that we will consider treatment in a hospital not on our lists or listed as an Extended hospital when you do not have it as a policy option is if there is a particular treatment that is only available in one particular hospital or given by one particular Consultant, i.e. there is a need of medical necessity.

In the event that you choose to use a hospital not on our lists or in an Extended Hospital list instead of one from the Partnership list, we will pay up to the costs of an admission for a procedure or medical care in a hospital which would have been available to you. Any additional costs will be your responsibility. This benefit is referred to as the 'out of band hospital benefit'.

Any medical costs and Consultants fees, including Surgeon and Anaesthetist fees must be paid within the customary and reasonable terms. By this we mean that it should be within the expected average cost, and for a particular procedure listed within the CS Healthcare Fee Schedule be billed within our published levels of reimbursement. Please refer to section 'Surgeon and Anaesthetist fees' and/or our website at www.cshealthcare.co.uk for further details or call the Claims Helpline on 020 8410 0440.

G4 Any condition or policy change which has a personal exclusion listed against it as described on your Registration Certificate will not be covered. In addition a non-disclosed condition, be it accidental or intentional will not be covered, this includes any fertility or reproductive conditions which are confirmed up and until the inception date of your policy.

G5 War, Terrorism and Contamination: Any treatment for an illness or injury arising out of war, invasion, the act of a foreign enemy, hostilities (whether declared or not), civil war, riot, civil commotion, act of terrorism, rebellion, revolution, insurrection, or military or usurped power.

Any treatment required as a result of contamination with radiation and chemical or biological substances either in relation to the events listed directly above or as a result of an industrial accident.

G6 Treatment abroad/overseas for UK residents (by overseas we mean any country outside of the United Kingdom). The Society will consider requests for treatment within the European

Economic Area (EEA), in line with the E112 scheme or Article 56 of the European Community; if there is a medical need such as an unacceptable waiting period to receive treatment within the United Kingdom (UK) or if there is a particular need which requires an individual to have planned treatment within the EEA. This will be dependent on your UK based Specialist Consultant having consented to the treatment as being appropriate and that you are fit to travel, then consideration to authorisation can be given.

The planned treatment will only ever be reimbursed up to the value of treatment of the same complexity and to the value of those charges which would have been incurred at a hospital as listed in the Directory of Hospitals. Consultants Fees will be paid in line with the CS Healthcare Fee Schedule. This will be subject to you pre-authorising your treatment and receiving a written offer of cover from CS Healthcare.

If you have planned NHS funded treatment within the EEA we will consider authorisation of the NHS cash allowance according to the average length of stay for a particular procedure had it been undertaken within the NHS in the United Kingdom, subject to any medical complications.

G7 Can I continue my policy if I go to live abroad? Your policy provides cover for specific eligible treatment that takes place in the United Kingdom. It is important that you notify us in writing before you take up residence abroad and note that you may not be able to claim for treatment in your country of residence. You will not be covered for treatment that takes place outside the UK unless it has been arranged under the European Economic Area (EEA) reciprocal arrangements and we have agreed to the cover as specified in clause G6. For the purpose of living abroad the appropriate insurance policy to cover that countries health needs should be considered.

If you choose to keep your policy and return for treatment to the United Kingdom, you will not be covered for any travel costs incurred to necessitate your return and you will also need to use a hospital from the Directory of Hospitals in line with your level of cover. Please refer to the Directory of Hospitals for more information. Should you return to the UK and use the policy for treatment it must be on the referral of a General Practitioner or an appropriate referring medical doctor from your country of residence.

You should contact us for pre-authorisation of your claim before proceeding with treatment. If you do not have a General Practitioner in the United Kingdom, and incur private General Practitioner fees either in the United Kingdom or in your country of residence, you will not be able to claim these fees on your policy.

G8 Professional Sports:

Any illness or treatment resulting from an injury sustained as a result of taking part in a sport for which you are receiving a salary, monetary reimbursement including sponsorship or for which you regularly represent your country.

Specific Treatment Exclusions and Advice

Specific Exclusions give details of those particular conditions and related medical services which are **not** covered. For clarity, the aspects which are covered under the policy are detailed directly under each section.

The Society will not cover:

S1 Unlicensed/Experimental treatment:

What is not covered:

- X Drugs which do not appear in the Compendium of Product Licenses issued by the Association of British Pharmaceutical Industry.
- X Any treatment being medical or surgical including the use of prosthesis not based on established medical practice is unproven or experimental, and has not been assessed by the National Institute of Health and Clinical Excellence.
- X The cost associated with treating or correcting the direct complications of unproven or experimental treatment including unlicensed drugs in any circumstance.
- X Consultations and investigations associated with the collection of trial data.

What is covered:

- ✓ Where there is an alternative 'conventional' treatment available which the Society would have covered; we will offer the level of reimbursement we would have paid for the hospital, Consultant and Anaesthetic Fees, as long as the patient/member has fully consented to the alternative experimental treatment, and understands that any direct complications of the experimental treatment will not be covered by the Society. Any extra costs may have to be paid by you.

S2 Chronic or Long-term Conditions:

What is not covered:

- X Care of a condition which continues indefinitely and has no known cure.

- X Care of recurrent symptoms which come back or are likely to come back.
- X Care of a permanent condition, including congenital or birth defects.
- X Care of a condition for which rehabilitation or specialist training is required to cope with it.
- X Care of a condition which requires long-term and regular monitoring, consultations, check-ups, examinations and tests. The long-term administration of blood transfusions and Kidney Dialysis.
- X Blood tests and monitoring of medications and changing of prescription drugs not associated with acute episodes.
- X Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS) and any condition directly related or attributed to these conditions.

What is covered:

- ✓ Treatment of acute conditions or symptoms curable in the short-term either by surgery or medical intervention which is proven and has been reviewed by NICE (National Institute of Health and Clinical Excellence).
- ✓ Diagnostic tests and consultations and treatment to stabilise symptoms of a newly diagnosed condition.
- ✓ Acute Episodes or recurrent symptoms of a diagnosed chronic condition requiring a surgical or medical admission or a short course of out-patient consultations or treatment to stabilise the condition. This includes pre-authorised in-patient admissions to a general ward, but emergency life saving treatment including an admission to a critical care setting is not covered.

S3 Acute Conditions:

What is not covered:

- X Emergency care in an Accident and Emergency or a Casualty Department (including private facilities), and immediate life saving surgery and treatment in a Critical Care Setting.
- X Any acute condition covered by a Personal Exclusion or by the Moratorium terms of your policy. See 'General Policy Exclusion' rule G4.
- X Long-term stays in a Critical Care Setting.
- X Organ transplants, including artificial organs and ventricular assist devices, and the aftercare, maintenance and related complications of having received a transplant or any treatment related to having been an organ donor.
- X Treatment for the recovery and transplantation of bone marrow and autologous bone marrow/stem cell transplantation.
- X Illness or injury arising through contamination with radioactivity.

What is covered:

- ✓ Pre-authorised treatment of acute conditions and

symptoms curable in the short-term and acute episodes of chronic/long-term illnesses in either an out-patient environment or in a general ward setting.

- ✓ Pre-authorised treatment in your hospital choice of Partnership or Extended as listed in the Directory of Hospital (please see 'General Policy Exclusion' rule G3).
- ✓ Care in a Critical Care unit only when associated with a pre-authorised surgical admission (operation) or medical stay for an acute phase of treatment.

S4 Pregnancy:

Pregnancy is generally not covered under this scheme:

What is not covered:

- X Any antenatal care is not covered including the treatment of pre-eclampsia, eclampsia, and placenta previa and foetal screening.
- X Any fertility treatment, including secondary fertility treatment and investigations of recurrent miscarriage are not covered, unless an underlying medical cause requiring surgical treatment is identified and the details are submitted from the treating Consultant to CS Healthcare for our consideration.
- X Any labour either spontaneous or planned is not covered; including a ventouse and forcep deliveries.
- X Emergency Caesarean Sections for any medical reason.
- X Neonatal Care – care of a premature or full-term baby in a special care baby unit (Neonatal Unit) is not covered.
- X Foetal Surgery and Blood Transfusion.
- X Intentional termination, (abortion).
- X Congenital or birth defects.

What is covered:

A pregnancy confirmed after the inception date of your policy will be covered for the following:

- ✓ A planned Caesarean Section that is required for a reason of medical necessity, of which the details have been submitted from the treating Consultant, to CS Healthcare for our consideration, or transfer to a private ward following an emergency caesarean section provided no critical care is required.
- ✓ Planned removal of an Ectopic Pregnancy (pregnancy outside the womb).
- ✓ Planned treatment of a Hydatiform Mole (molar pregnancy).
- ✓ Evacuation of retained products of the womb following miscarriage or pregnancy.
- ✓ Induction of abortion for foetal abnormality.
- ✓ Insertion of a Shirodkar or Purse string suture for an incompetent cervix.
- ✓ Complications of any of the above and any medical complications requiring stabilisation

following delivery, excluding treatment in a Critical Care Unit.

S5 Dental Treatment:

Dental treatment is generally not covered under this scheme:

What is not covered:

- X Any routine dental treatment including the cost of providing and fitting dental appliances, and treatments such as root canal, crowns and dental implants.
- X Any orthodontic treatment including the cost of providing and fitting braces and other related appliances.
- X Any periodontal treatment including the care and treatment of gum disease.
- X Any cosmetic dentistry including teeth whitening for any reason.
- X The cost of a Dental Surgeon to complete a Claim Form.

Please note: The above applies with the exception of those benefits available under the Cash Benefits option.

What is covered:

Pre-authorised treatment by a Dental or Oral Facial Maxillary Surgeon in a Surgical Dental Centre or a hospital listed in our Directory of Hospitals where sedation or general anaesthetic is required for one of the following:

- ✓ Hospitalisation for dental treatment where anti-coagulant therapy requires management is covered under the policy terms.
- ✓ Replantation of teeth/tooth following an accidental injury that has occurred after the policy joining date of the particular claimant, and the replantation takes place immediately following the accident with your own tooth/teeth.
- ✓ Surgical removal of impacted/buried tooth/teeth.
- ✓ Surgical removal of complicated buried roots.
- ✓ Surgical drainage of a dental abscess.
- ✓ Surgical removal of a jaw cyst or tumours including malignancy.
- ✓ Treatment of facial fractures also described as mandibular, zygomatic or maxillary fractures; including internal or external fixation.
- ✓ Surgical treatment for Temporomandibular Joint (TMJ) Dysfunction.

S6 Cosmetic and Lifestyle Treatment:

Cosmetic and Lifestyle Treatment is generally not covered under the scheme:

What is not covered:

- X Surgical removal of any non diseased body tissue or part for preventative measures; and non acute conditions, including if there is a family history of

cancer or for psychological reasons.

- X Cosmetic or aesthetic treatment and surgery including for psychological reasons.
- X Weight Loss (Bariatric Surgery) like gastric banding or gastric bypass.
- X Breast Reduction Surgery for any reason.
- X Restorative or cosmetic care for pre-existing conditions or as a result of surgery or accidents not previously covered by us.
- X Correction of short or long sightedness including corrective lens implants and astigmatisms.
- X Speech Therapy for non medical conditions.
- X Sex change (gender reassignment) for any reason, including the related medical and psychological treatment.
- X Birth Control, including sterilisation, vasectomy and insertion of Intrauterine Devices (IUD's).
- X Sexual Dysfunction (including Erectile Dysfunction).
- X Treatment in a Health Hydro, Health Farm, Spa or Clinic and Rehabilitation centre or any form of respite care, and in-patient stays for domestic reasons which are not related to a medical need, even if the facility is registered as a private hospital.
- X The treatment of snoring and the related symptoms and the condition of Sleep Apnoea; including Continuous Positive Airway Pressure (CPAP) treatment or the like and any form Uvuloplasty.
- X Treatment of Sexually Transmitted Diseases.

What is covered:

- ✓ Reconstructive Surgery following previous treatment for a malignant condition which was covered by us (including a claim for NHS cash allowance) under Heart & Cancer option; for example breast reconstruction following a mastectomy for breast cancer within the 5 year necessary aftercare terms.
- ✓ Reconstructive Surgery following a traumatic accident which occurred while you have a current policy with CS Healthcare.
- ✓ Correction of post-operative complications and infection which require plastic surgery for a condition which was covered by CS Healthcare under either the Essential or Heart & Cancer option.
- ✓ The investigations of acute high blood pressure (Hypertension) and related heart conditions when related to Sleep Apnoea Central Sleep Apnoea and/or Central Sleep Apnoea, under the direction of a Cardiac or Neurology Consultant or a Sleep Specialist holding an NHS Consultants post under the Expert Diagnostics option.

57 Psychiatry & Out-patient Counselling:

There is limited cover for this type of treatment under Expert Diagnostics option.

What is not covered:

- X Day or In-patient care in a psychiatric hospital or clinic.
- X Treatment for alcoholism, solvent and drug abuse or any addictive condition.
- X Treatment for eating disorders and other self-inflicted illnesses.
- X Self-inflicted illness, injury or disability or associated medical conditions.

What is covered:

- ✓ Out-patient Psychiatric Consultations and Counselling under the care of either a Consultant Psychiatrist or Psychotherapist or a recognised Counsellor.
- ✓ Out-patient assessment by a Neuro-psychiatrist or Psychotherapist to aid the diagnosis of certain neurology conditions such as Parkinson's Disease or Alzheimer's Disease.

Always check the credentials of your practitioner before incurring any medical expenses. You are covered to see:

Consultant Psychiatrist or Psychotherapist who holds or has held a substantive NHS post or holds a certificate of Higher Specialist Training in these given specialities issued by the Royal College of Psychiatry or the General Medical Council in accordance with EU directives or a Counsellor or Psychotherapist registered with the Health Professionals Council of the United Kingdom.

58 Out-patient Services; Drugs, Appliances and GP:

What is not covered:

- X Any benefits listed in the Expert Diagnostics option and the Therapy & Care option, if you have not chosen it as an option and are not currently paying a premium for it.
- X Appliances and Aids not directly associated with the benefits under the Therapy & Care option.
- X Treatment that has fallen outside the 90 day Necessary aftercare terms of the Essential option.
- X Treatments that have fallen outside the 1 or 5 year necessary aftercare terms under the Heart & Cancer option.
- X Treatment in an Accident and Emergency or Casualty department.
- X The reimbursement of private fees for a General Practitioner any other medical practitioner, *Dentist and *Optician (*Unless covered under the Cash Benefits options).
- X The cost associated with the completion of a Claim Form or medical report.
- X Out-patient drugs (medicines), dressings and nutritional supplements, including take home drugs following any hospital admission (unless used in the course of chemotherapy under the Heart & Cancer option).

- X Hormone Replacement Therapy.
- X The general maintenance of foot conditions like corns, hard skin, and toenail maintenance.
- X The cost of assessing, fitting and providing an external prosthesis, hearing aid (including cochlear implants) and spectacles/contact lenses (unless you are covered under the Cash Benefits option).
- X Assessment and treatment of learning or developmental difficulties or special educational needs including, but not limited to, Autism and Autism Spectrum Disorders, Attention Deficit Hyperactivity Disorder (ADHD) Dyslexia and Dyspraxia; and congenital and growth disorders.
- X Preventative treatment, Health Screening (unless you are covered under the Cash Benefits option) and vaccinations.
- X Genetic testing/Preventative screening.
- X Maintenance therapy.

What is covered:

- ✓ Any benefits listed in the Expert Diagnostics option and the Therapy & Care option, if you have chosen it as an option and are currently paying a premium for it. Please refer to the 'Expert Diagnostics' and 'Therapy & Care schedule of benefits' – within this Policy Document for a full list of benefits.
- ✓ Necessary aftercare within 90 days of surgery or a medical admission as available under Essential.
- ✓ Necessary aftercare within 1 year of a cardiac procedure or
- ✓ Necessary aftercare following the initial date of the primary diagnosis of cancer for a maximum of 5 consecutive years under the Heart & Cancer option.
- ✓ Allergy assessment when undertaken by a Consultant holding an appointment at NHS Allergy Clinic or a Consultant recognised by the British Society for Allergy and Clinical Immunology. (Find a Clinic at www.bsaci.org/clinics.html or call the allergy UK infoline at 01322 619898).

Policy Administration

Joining

The minimum age for a policy holder to join CS Healthcare is 18 years and the maximum age to join is 74 years and 11 months.

Dependants can be included on the policy at the time you join or can be added at a later stage. New born children can be added, without any evidence of health, provided they are registered within two months of birth. However, it is important to note that treatment for the purposes of, or related to, any neonatal care or surgery commencing within three months of delivery will not be covered (please

refer to 'Specific Exclusions and Advice' section rule S4 within this Policy Document). No premium will be payable for them until the renewal date after their 1st birthday. The adult rate will be applied from the renewal immediately following their 18th birthday.

Children may remain on the Member's policy until the renewal immediately following their 25th birthday. At this time we will write to both the Member and adult dependant to explain the change and to invite the adult dependant to join the Society in their own right.

The Society may impose special terms on an individual membership including, but not limited to, exclusions of specific medical conditions, restrictions on particular benefits, discounts or surcharges on the contribution rates. Any such special terms will be confirmed in writing by the Society at the time of registration, renewal or transfer.

In some instances we may require additional information from either a GP or other health professional who is involved in your treatment or care, any expense incurred for this will have to be covered by you.

Where there is a current medical condition, (where treatment or care is planned or currently being undertaken) underwriting terms in the form of a personal exclusion may be applied for either a six month waiting period or longer if appropriate. This means you may not be able to use the benefits for your chosen scheme change immediately. This may include restricting your access to a hospital available under your previous cover for a specific condition in some instances.

Switching your health insurance to CS Healthcare

If you are already insured by an existing insurer, you may be able to switch your health insurance provided you have been insured within the last **60 days** prior to joining. Please refer to 'Switching your health insurance to CS Healthcare' section on page 30 for the terms and conditions.

Renewing

The period of each policy is one year from the effective date shown on the Registration Certificate. At the end of that time your policy will automatically renew on the same terms (unless you advise us otherwise in writing), for another year if the plan is still being offered.

We will write to advise you of any changes to your policy at least 21 days before your renewal date.

At the date of your annual renewal, or at the discretion of the Society, you can write to us and request to increase your level of cover, remove an

excess or co-payment or transfer to a different plan. We will make the change effective from your renewal date and adjust your premiums appropriately. Any existing personal exclusions which are listed on the policy will remain in place. The Society may refuse or accept the request.

Increasing cover – adding options/removing or decreasing an excess/changing choice of hospital band

Examples of an increase in cover is adding another option to your current health insurance cover or decreasing an excess. If you wish to increase your cover please contact the Membership Services Team on 020 8410 0400 at least 15 working days before your renewal date.

To increase cover on the Cash Benefits option, for example a move from Level 1 to Level 2, please contact the Membership Services Team on 020 8410 0400 at least 15 working days before your renewal date. As this change is effective from the renewal of your policy no additional qualifying period will apply i.e. claims up to the new benefit limit can be applied for without any additional waiting period.

Please note, increases in cover may result in you being re-underwritten and it may not be possible to increase your cover for current conditions. If this is the case, we will write advising you of any restrictions, so that you have the opportunity to reconsider your decision to change.

IMPORTANT NOTE: Increases to cover can only be made at renewal with notification being given to the Membership Services Team at least 15 working days before your renewal date.

Reducing cover or cancelling particular options from your policy

A reduction in cover includes taking out or increasing a voluntary excess or moving from 100% cover to co-payment (applicable to Essential, Expert Diagnostics and Heart & Cancer).

Please note you cannot have an excess if you are on the co-payment scheme.

If you wish to cancel options (excluding Essential) from your policy and/or increase your excess or co-payment option please contact the Membership Services Team on 020 8410 0400 providing at least 15 days notice.

Details of the contributions for each of these options are shown on the rate sheet. Please refer to the 'Voluntary Excess and Co-payment Options' section within this Policy Document for information as to how the excess and co-payment work.

IMPORTANT NOTE: Reduction in cover can be made at any time providing at least 15 days notice has been provided in order to process your request. Changes will be effective from the following month of cover.

Redundancy of policyholder

If the Member is under the age of 60, working at least 35 hours each week becomes unemployed through involuntary redundancy, contributions will be suspended and funded by the Society on behalf of the Member until the next renewal date of the policy. In order to qualify for this benefit, the following conditions will apply:

- (a) you must have been a member of the Society for at least three months; and
- (b) you have been continuously unemployed for at least three months; and
- (c) you have not accepted voluntary redundancy, or become unemployed as a result of self-inflicted injury, or the consumption of alcohol or taking drugs unless under qualified medical advice, or deliberate misconduct, or upon completion of a fixed term contract; and
- (d) you were not aware of forthcoming redundancy when you joined the Society, or knew that you were likely to become unemployed.

In support of the member's claim for premium waiver, we will require evidence from your previous employer that you have been made redundant and proof of your unemployment registration.

If premiums are paid annually, then they will be refunded on a pro-rata basis for whole months only (if applicable), and if any pre-payment discount was included in the annual premium this will be taken into account for the refund.

We will continue to fund your premiums until the first of the following occurs:

- (a) you cease to be unemployed, or commence working for 18 hours a week or more
- (b) you cease to be registered for work at a government employment agency
- (c) you fail to provide proof upon request of your continued registration
- (d) your policy renewal date.

Death of policyholder

On the death of a Member, any dependant held on the deceased's health insurance policy shall have that cover extended without payment of contributions for the period up until the next policy renewal date.

If premiums are paid annually, premiums will be refunded on a pro-rata basis for whole months only (if applicable).

If the member dies the policy will automatically be

transferred to the oldest insured person over the age of 18 years who shall become the main policyholder for the purposes of this policy and be responsible for paying the premiums.

Cancellation of a policy (of Essential and whole policy)

New members and those renewing may cancel membership within 15 days of receiving their policy documentation and a full refund will be given provided that no claims for benefit have been submitted during the policy year.

Members may cancel their policy at any other time by notifying us in writing. Monthly premium payments will cease from the next instalment date, provided at least 15 working days notice has been given. If premiums are paid annually, they will be refunded on a pro-rata basis for whole months only (if applicable), less any pre-payment or introductory discount.

If you choose to cancel your membership, you may re-register on the same terms and conditions within 90 days. Membership must be continuous, so any premiums that would have fallen due within the 90 days will need to be paid in full before your policy can be re-instated. After this 90 day period you may re-apply to be a member of CS Healthcare but will be required to be re-underwritten (see 'Re-joining' section of this document).

Re-joining

Any person wishing to re-join the Society may apply to do so. Neither you nor your dependants will have an automatic right to re-register with us, or an automatic right to re-register on the same policy terms and conditions on which you were previously a member. Your application may be made subject to further underwriting.

Voluntary excess and co-payment options

Voluntary excess – applicable to Essential, Expert Diagnostics and Heart & Cancer options only

The Voluntary excess is the amount of expenditure which you have agreed to pay each policy year in return for receiving a reduction in your policy premiums. If you have opted for a voluntary excess on your health insurance, the excess will apply to each person for each policy year, until the excess amount is reached. Therefore each time an invoice for eligible pre-authorised treatment is received, it must be sent in to CS Healthcare, so it can be assessed and offset against the excess. The excess counts towards each individual on a policy for the

chosen yearly excess and not counted against each condition claimed for.

For example:

David has a chosen excess of £100. The cost of his pre-approved treatment is £80. The Society will not pay any benefit to David as the treatment costs do not exceed £100.

However, David will need to send the invoice to CS Healthcare to offset against his excess, and would need to settle the £80 himself. As £80 has been offset against the excess, leaving a balance of £20 remaining for the remainder of the policy year.

He then undergoes further treatment in the same policy year and incurs further treatment costs of £150. As David has a remaining balance of £20 on his excess we can pay £130 towards these costs. CS Healthcare will pay £130 directly to the provider, and will inform David that he needs to settle the balance of £20.

IMPORTANT NOTE: The excess starts again at the beginning of each new policy year, (at your renewal date) even if treatment is ongoing and spans more than one policy year. Therefore, where treatment starts in one policy year and continues to the next, the excess will apply again.

Co-payment – applicable to Essential, Expert Diagnostics and Heart & Cancer options.

The co-payment option is the proportion that you have agreed to pay towards the cost of all eligible treatment. The co-payment proportion will be applied to each invoice that you claim for.

For example:

You have chosen a co-payment of 15% on your policy. You make a valid claim for an invoice totalling £1000. We pay £850. Your liability is £150.

Whilst the co-payment proportion is applied to each policy year, the maximum that you will be liable for in a policy year is £1,500 for each person covered under your policy.

Underwriting Terms and Personal Exclusions

Underwriting is the process by which an insurer decides on what terms it will accept a person for cover based on the information they supply. This section is designed to explain the methods by which you can apply for cover, so that you can decide which one best suit your requirements.

When you completed your application to join you

should have provided full and accurate information. Failure to do so may mean that we cannot cover a claim or will result in your policy being cancelled. If you are unsure whether we would want to know about a particular condition, or you have since remembered something you should have declared, you should tell us about it as soon as possible so we can advise you if your cover may change or whether a further personal exclusion may have to be added to your policy terms.

When joining the following methods of underwriting are available to you.

Full Medical Underwriting

This is based on completing a health questionnaire (also called a Medical History Declaration).

If you choose this option, you will be asked a number of questions about your health. These will enable us to understand your medical history (and that of any dependant whom you wish to insure). It is important that you consider the questions carefully, for each person to be covered, and answer them fully. We will review your details and decide the basis on which we can accept you for cover. If necessary, we may need to ask your doctor for further information to help us to do this, if this is the case you will be liable for any costs associated with obtaining this.

If you have a pre-existing condition that may need treatment in the future, we will usually exclude it from the cover along with any conditions related to it. We will show any personal exclusions on the Registration Certificate you receive from us when we have processed your application. The same process will also apply for any dependants included in your application.

IMPORTANT NOTE: If you make a claim for symptoms that initially occur within the first year of your policy, we will ask you to provide a copy of the GP referral letter for assessment of your claim. This is to ensure we received all the correct information regarding the state of your health when you joined us.

What is the advantage of Full Medical Underwriting?

Although this option involves more of your time when completing your application, it does mean that, when you receive your policy documentation, you will know which conditions are excluded from cover. If you need to make a claim we will usually be able to authorise any required treatment over the telephone.

Review of Personal Exclusions

You may ask us to review a personal exclusion, this is usually after two full years of membership or

sooner if indicated on your Registration Certificate. For us to consider removal of a personal exclusion we will require a medical report from your General Practitioner (GP) confirming that the condition was cured, by which we mean that you have no active signs and symptoms, and you are not requiring regular medication or medical supervision.

There are some circumstances where we may be able to amend your underwriting terms for certain conditions, provided we are in receipt of a report stating that the condition has been stable and well controlled on medication for a period of more than 2 years. If you wish us to consider the removal of a condition, you should contact us before obtaining a report from your GP. If your GP makes a charge for issuing a medical report, this cost must be met by you.

It is important to understand that some medical conditions may never be reviewed if they require long-term and continuous care. Of course, any new medical conditions arising after the start of your policy will be covered immediately subject to the policy terms and conditions.

Moratorium Underwriting

With this option you do not need to fill in a health questionnaire. Instead, we automatically exclude any pre-existing conditions for which you (and any dependant included in your application) have received treatment and/or medication, or asked advice on, or had symptoms of (whether or not diagnosed), or have any pending health screening appointments or outstanding results during the five years immediately before your Private Health Insurance cover started.

However, if you do not have any symptoms, treatment, medication, or advice for those pre-existing conditions, and any directly related conditions, for two continuous years after your policy starts, then we will reinstate cover for those conditions.

You should understand that long-term medical conditions, which are likely to continue to need regular or periodic treatment, medication or medical advice, will never be covered by your policy.

You should not delay seeking medical advice or treatment for a pre-existing condition simply to obtain cover under your policy.

As with Full Medical Underwriting, new medical conditions arising after the start of your policy will be covered immediately subject to the policy terms and conditions.

In order to authorise treatment each time, your General Practitioner (GP) will be required to submit a copy of

the referral letter so that we can confirm if the condition is new or pre-existing. This procedure is continuous throughout the life of your policy. Your GP may charge you for this service for which you and not CS Healthcare will be responsible for paying. With Moratorium Underwriting we are unable to give automatic pre-authorisation for any new claim.

What is the advantage of Moratorium Underwriting?

If you choose this option you will only be asked to provide basic information about you and any dependants you wish to insure. You will not be asked to disclose details of your medical history, but it relies on you to understand that if you have any medical conditions these will be excluded from cover. Also, if you can satisfy the criteria (usually two years) outlined in the above section, for a pre-existing condition, then treatment for that condition will automatically be covered should it later recur, subject to the policy terms and conditions.

Switching your health insurance to CS Healthcare

The intention of our switch terms is to allow those with current or recent health insurance to join CS Healthcare, in most cases, with the same method of underwriting as their previous insurer.

It is important to understand there are certain types of treatment and pre-existing medical conditions which **may not qualify you for our switch terms**. These include, but are not limited to, stroke, cancer (including benign brain tumours), joint replacement and spinal conditions and any conditions/symptoms which are being investigated or treated. If you do not qualify for our switch terms, we will offer Full Medical Underwriting as an alternative.

Any disease, condition or symptoms of health which have arisen previously, will be assessed to decide if there are any specific pre-existing conditions that are likely to need treatment in the future for example, conditions recently diagnosed and/or awaiting surgery. **We may exclude these conditions from cover.**

It may be possible to carry over stable and well controlled pre-existing conditions to your CS Healthcare policy. Conditions may be restricted from cover for Routine Monitoring and Maintenance of long term chronic conditions. However, investigations or treatment for acute episodes will be covered under our policy terms and conditions for example, if a condition becomes destabilised or a routine test highlights an abnormality.

If you have had a recent investigation for symptoms/conditions (within the last 6 months) but the symptoms/conditions have since recovered, this would not prevent you from switching to us, although a short term exclusion for 6 months is likely to be applied.

Our underwriters will review your application and confirm any personal exclusions that may apply before the start of your policy. A premium loading may be applied to the policy to reflect the additional risk to the Society and, if so, this will be shown on your Registration Certificate. **We strongly suggest you do not cancel your existing insurance until we have confirmed in writing any personal exclusions which may apply to your policy.**

In order to apply for our switch terms you, and any dependant on the policy, must satisfy the following conditions:

- Currently insured under a UK health insurance policy, or had a policy which expired within **60 days** of your requested policy start date with CS Healthcare.
- The maximum age for any applicant or dependants at the proposed start date of the policy is **69 years and 11 months**.
- A copy of previous certificates of insurance for each dependant applying for switch terms must be provided to CS Healthcare. **Please note:** we will be unable to validate your cover or authorise any claims for benefit until we have received and reviewed your previous certificate of insurance. Additionally, if valid certificates are not received within 60 days of commencing your policy, cover may be terminated by CS Healthcare.

If your previous insurer has applied personal exclusions or special terms to your current/last policy, we would be happy to review these at application stage, if the condition is resolved or in a period of long-term stabilisation.

It is possible for a switch policy to include a combination of dependants who have/have not had health insurance before, as long as the main applicant qualifies for switch. We will review the medical history of any dependants that have not had previous health insurance and confirm any personal exclusions that may apply. **Please note:** current or active conditions or symptoms whether diagnosed or not may be excluded from cover.

The above terms and conditions apply to both Continued Personal Medical Exclusions (CPME) and Continued Moratorium (CM) underwriting terms.

Continued Personal Medical Exclusion (CPME)

CPME is a method of underwriting where CS Healthcare may be able to carry over stable and well controlled pre-existing conditions to your CS Healthcare policy. Some conditions may be restricted for Routine Monitoring and Maintenance of long term chronic conditions. However, investigations or treatment for acute episodes will be covered under our policy terms and conditions for example, if a condition becomes destabilised or a routine test highlights an abnormality. Please also refer to 'Switching your health insurance to CS Healthcare' section.

Continued Moratorium (CM)

This option is designed to continue the date the original Moratorium period became effective provided no symptoms have occurred or that no treatment, medication or advice has been received during this period. Please be aware that Continued Moratorium is subject to our underwriting rules therefore any pre-existing conditions that occurred during the last five years prior to the original Moratorium start date will be excluded from cover for that condition for a continuous period of two years. After this period the condition will become eligible for benefit subject to the policy rules.

In order to authorise treatment each time, your GP will be required to submit a copy of the referral letter so that CS Healthcare can confirm if the condition is new or pre-existing. Your GP may charge you for this service. Any new, unexpected eligible conditions arising after the start of your CS Healthcare policy will be covered immediately, subject to policy rules. Please also refer to 'Switching your health insurance to CS Healthcare' section.

Policy Rules

Membership terms

The terms of membership are set out in the current versions of the following documents all of which must be read together.

- any application form the Society asked you to complete
- Policy Document and Benefit Schedules
- Registration Certificate and letter of acceptance
- Directory of Hospitals
- Memorandum of Association & Rules
- Contribution rates
- any other document setting out information affecting the rights and obligations of the Society and you concerning membership.

These policies confer no financial interest in the Society except for the benefits they describe.

Premium payments

Premium payments can be paid annually or monthly in advance on the policy inception date and each time your policy renews.

A 4% discount will be given to members who pay a single annual premium payment in advance by either Direct Debit, Debit Card or Cheque. Alternatively a 2% discount is available if the annual premium is paid by Credit Card.

The Society will determine the amount of the premium payable at the start of each policy year and will advise you at least 21 days in advance.

We can increase or reduce the premiums you pay at any time if there is an increase or decrease in the rate of Insurance Premium Tax or any other government or statutory change, existing or introduced. If we do so we will only increase the premiums you have to pay to cover the cost to us of the changes in the taxes or charges. We will write to you at least 21 days before increasing your premiums.

How to make a complaint

The Society makes every effort to ensure that members are satisfied with the level of service we provide. However, if things do go wrong we have an open and fair complaints procedure. In the event that you are unhappy with our service, please contact us to explain the reason for your dissatisfaction:

Write to:

Civil Service Healthcare Society Limited,
Princess House,
Horace Road,
Kingston upon Thames,
Surrey,
KT1 2SL

Telephone the Membership Services Team on
020 8410 0400

We will investigate your complaint and provide you with a written response. If you are unhappy with the outcome of our investigation you may refer the matter to the Financial Ombudsman Service.

Their contact details are:

South Quay Plaza,
183 Marsh Wall,
London
E14 9SR

Telephone: 0845 080 1800

E-mail: complaint.info@financial-ombudsman.org.uk

The complaints procedure is set out in Rule 42 of the Society's Memorandum of Association & Rules.

Our complaints procedure is without prejudice to your right to take legal proceedings.

We are covered by the Financial Services Compensation Scheme, and you may be entitled to compensation from the scheme if we are unable to meet our obligations to you. Most types of insurance business are covered for 100% of the first £2,000 of a valid claim and 90% of the remaining amount of the loss within the terms and conditions of your policy. With effect from 1st January 2010, non-compulsory insurance will be covered for 90% of the claim, with no upper limit. Further information about compensation arrangements are available from:

The Financial Services Compensation Scheme
7th Floor,
Lloyds Chambers,
Portsofen Street,
London,
E1 8BN
Telephone: 020 7892 7300

How we use information about you

Confidentiality

The confidentiality of patient and member information is of paramount concern to CS Healthcare. To this end we fully comply with Data Protection Legislation and Medical Confidentiality Guidelines.

Consent

In becoming the main policyholder you have sought and agreed to act on behalf of any other person included within the policy. As such all membership documents and confirmation of how we have dealt with any claim/s under the policy will be sent to you.

Telephone calls

In the interest of continuously improving our service to members, your call will be recorded and may be monitored for training, quality assurance purposes and/or prevention and detection of crime.

Regulation

CS Healthcare is authorised and regulated by the Financial Services Authority (FSA). Our FSA Register number is 205346. Our permitted business is to provide private health insurance contracts. You can check this on the FSA's Register by visiting the FSA's website at www.fsa.gov.uk/register or by contacting the FSA on 0845 606 1234.

How we may use your personal information

- Medical information or records will only be disclosed to those involved with your treatment or care, including your GP, or to their agents and if applicable, to any person or organisation who may

be responsible for meeting your treatment expenses, or their agents.

- CS Healthcare sometimes uses third parties to process data on its behalf, if you would like further information as to these third parties please write to the Data Protection Officer.
- CS Healthcare would like to keep you informed by telephone, post or email of future products, services and special offers available from us.
- CS Healthcare would like to keep you informed by telephone, post or email of selected products, services and special offers available from carefully selected third parties. We may also share your information with other carefully selected third parties for business analysis and market research purposes.
- To aid CS Healthcare in the detection and prevention of fraudulent claims we may disclose personal information about you to fraud prevention agencies that in turn may record, use and distribute this personal information to other organisations. In addition we work collectively with other organisations to share information relating to fraudulent/suspicious claims. If you would like further information as to these third parties please write to the Data Protection Officer.
- Under the terms of the Data Protection Act 1998 you are entitled to request a copy of the information we hold about you. We reserve the right to charge an administrative fee for supplying this service up to the maximum that the Data Protection Act 1998 permits. If you would like to make a request to receive a copy of such information please write to the Data Protection Officer.
- For all data protection queries please write to the Data Protection Officer at Civil Service Healthcare Society Limited, Princess House, Horace Road, Kingston upon Thames, Surrey, KT1 2SL.

Access to Medical Reports Act (1988):

Sometimes we need to get a medical report from a doctor who has cared for you before we can make a decision on your application/claim. The Access to Medical Reports Act 1988 gives you certain legal rights which are:

- We need your agreement before we can apply for a medical report from your doctor. You can refuse but if you do we will not be able to assess your application.
- You can ask to see the report before your doctor sends it to us, or for up to 6 months after. If you wish to see the report, please tick the relevant box on the Access to Medical Reports Form in the

Proposal Form to indicate you want to see the report. This may delay the assessment of your application and your doctor can charge you a reasonable fee to cover costs.

- If you think a part of the report is incorrect or misleading when you see it, you can ask your doctor to have it changed.
- If your doctor will not agree to do this, you may attach a statement of your own.

You will not be entitled to see any part of the report which:

- The doctor believes could seriously harm your physical or mental health, or that of others.
- Indicates the doctor's intentions in respect of you.
- Reveals information about another person, or the identity of someone who has given the doctor information about you (unless that person consents or is a health professional involved in caring for you).

We will write and tell you when we request the report. If you've asked to see the report before your doctor sends it to us, you will have 21 days from the receipt of our letter to contact your doctor. Once you have seen the report, your doctor needs your agreement to send it to us. If you don't arrange to see the report within 21 days, your doctor will be free to send it to us.

Definitions

The words and phrases set out below have special meanings.

Accommodation

The charge made by the hospital for in-patient or day-patient treatment which includes the cost of the bed, meals, routine nursing and housekeeping.

Acute Medical Condition/Acute

A disease, illness or injury that is likely to respond quickly to treatment which aims to return you to the state of health you were in immediately before suffering the disease, illness or injury, or which leads to your full recovery.

Benefits

The items listed under each available **your choice** option for which you can claim the reimbursement of medical costs or receive a daily cash sum for an NHS stay in an acute general hospital.

Benefits schedule

The schedule of benefits of your chosen plan showing the maximum benefits we will pay for each insured person. This is also known as Schedule D.

Cancer

A malignant tumour, tissues or cells, characterised

by the uncontrolled growth and spread of malignant cells and the invasion of tissue; and for the purpose of claiming under the Heart & Cancer option any brain tumour requiring surgery or chemotherapy or radiotherapy.

Chronic Medical Condition (long-term)/Chronic
A disease, illness or injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check ups, and/or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires your rehabilitation or for you to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back.

Claim

The benefits a member asks us to pay in respect of treatment for an eligible condition.

Continued Moratorium (CM)

A method of underwriting that is designed to continue the date of the original Moratorium period from your previous insurer.

Co-payment

The 15% of medical expenses, which you have agreed to pay towards the cost of all eligible treatment, subject to the limit of £1500 per person per policy year.

Convalescence Care

The care required to recuperate from either a surgical or non surgical (medical) in-patient admission, in a registered care / nursing home for a maximum of 14 days following a patient's immediate discharge from hospital.

Continued Personal Medical Exclusions (CPME)

A method of underwriting where CS Healthcare may continue any personal medical exclusion applied by their previous insurer – any new conditions that are awaiting surgery or diagnosis that have arisen whilst being insured will be re-underwritten.

Critical Care

Treatment given in either a resuscitation room, intensive care or high dependency unit, including coronary care units, which requires the specialist care, supervision and support by intensive care specialists.

Customary and Reasonable

Your benefits state that you are 'Covered'. By this we mean that all costs must be necessary, customary and reasonably incurred at a hospital

from the appropriate part of the Directory of Hospitals or as previously agreed by us, and that all Surgeon and Anaesthetist fees will be paid in full according to the rates of the CS Healthcare fee schedule. All other incurred cost must be within average and acceptable levels appropriate for the services provided.

Day-patient treatment

A patient who is admitted to a hospital or day-patient unit because they need a period of medically supervised recovery but does not occupy a bed overnight.

Dental, Orthodontic and Periodontal procedures

The following procedures are covered under your policy provided the treatment is carried out as a medical necessity under general anaesthetic, by a Dental or Facial Maxillary Surgeon practising in a hospital included in our Directory of Hospitals:

- Replantation of teeth/tooth following an accidental injury that has occurred after the inception date of your policy, and the replantation takes place immediately following the accident with your own tooth/teeth.
- Surgical removal of impacted/buried tooth/teeth.
- Surgical removal of complicated buried roots.
- Surgical drainage of dental abscess.
- Enucleation of cyst of jaw.
- Treatment of mandibular, zygomatic or maxillary fractures including internal or external fixation.
- Excision or resection of mandible or maxilla, including removal of malignancy.
- Maxillary osteotomy and prosthetic surgery.
- Open operations of the jaw including the temporo-mandibular joint.
- Hospitalisation for dental treatment where anti-coagulant therapy requires management.

Dependant

Your legal or civil partner including married and separated couples and your natural children, legally adopted children, partner's children or stepchildren or children where you are the legal guardian. All children must be under the age of 25. This does not include a person living with you or any other members of your family, no matter how long the period.

Diagnostic tests

Investigations, such as X-rays, blood tests and ECG to find or to help to find the cause of your symptoms.

Directory of Hospitals

The document published by the Society which lists the Partnership or Extended hospitals whose charges have been agreed with the Society and you may use subject to which hospital option you have

chosen. Partnership will cover you for a wide choice of provincial hospitals and a selection of London Hospitals. Extended will cover you for the central London Hospitals.

Emergency treatment

Treatment received in an NHS, private casualty or Accident and Emergency Unit, including immediate life saving surgery and treatment in a Critical Care setting, to care for an immediate life threatening condition or to repair or assess a medical condition or symptoms.

Excess

The amount of expenditure which you have agreed to pay each policy year towards the cost of eligible treatment for each person covered on the policy, in return for receiving a discount on your premiums.

Full Medical Underwriting (FMU)

A method of underwriting where you are asked to give details of your medical history.

General Practitioner (GP)

A medical practitioner holding a Certificate of General Practice Training and registered with the General Medical Council in the United Kingdom.

Health Screening

Health Screening is defined as Wellwoman screening, and Wellman screening, Breast Cancer screening, Osteoporosis screening, Bowel Cancer screening, Cervical Screening and Executive Check-ups at a recognised screening centre under the care of a physician.

In-patient treatment

A patient who is admitted to hospital and who occupies a bed overnight or longer for medical reasons.

Insured person

The member and any insured dependants for whom we are receiving a premium/payment for a CS Healthcare policy.

Medical necessity

Diagnostic investigations and treatment including surgery that is required to cure, correct and stabilise an acute medical condition.

Medical practitioner

A person registered or whom the Society accepts as a medical practitioner. (Please refer to the Specialist/Consultant definition within this section).

Member

The policyholder with whom we have made the membership and who is responsible for paying the premiums for a CS Healthcare policy.

Moratorium

A method of underwriting offered at the time of

joining where you do not declare any medical history. However, all pre – existing conditions or symptoms (whether diagnosed or not) which have been in existence for 5 years prior to your join date will not be covered until a 2 year period has passed where no treatment or medical supervision of any kind has been confirmed.

Necessary aftercare

The period directly after you have been discharged, you will be covered for a 90 day period of necessary aftercare, this will normally cover up to a maximum of 3 post-operative or follow-up consultations, a period of physiotherapy, 6 sessions in the first instance, where related directly to your surgery or medical admission to check your progress or treat any complications. Wound care and dressings and small procedures will also be covered where they are a direct consequence of your surgery or medical admission. Where a diagnostic procedure like an endoscopy or biopsy has been performed ongoing diagnostic consultation and tests will not be covered. Where you have chosen the Heart & Cancer option the period of necessary aftercare will continue subject to pre-authorisation for 1 year for cardiac conditions and for 5 years for cancer conditions.

Nurse

A qualified nurse who is on the register of the Nursing and Midwifery Council (NMC) and holds a valid NMC identification number.

Out-patient

A patient who attends a hospital, consulting room or out-patient clinic and is not admitted as a day-patient or an in-patient.

Overseas

A country outside of the United Kingdom.

Plan

The **your choice** health insurance plan is made up of the compulsory Essential cover and the additional Expert Diagnostic option, Therapy & Care option, Heart & Cancer option and Cash Benefits option. In addition there is a choice of hospital coverage from either the Partnership and Extended lists within the Directory of Hospitals.

Planned treatment

Admission to hospital by means of a waiting list or direct Consultant referral and not from the hospital Accident and Emergency unit or following a request for immediate admission on the advice of a GP.

Policy

The insurance contract between you and us, including the following documents which are sent to you from time to time:

- any application form the Society asked you to complete

- Policy Document and Benefit Schedules
- Registration Certificate and letter of acceptance
- Directory of Hospitals
- Memorandum of Association & Rules
- Contribution rates
- any other document setting out information affecting the rights and obligations of the Society and you concerning membership.

Pregnancy

CS Healthcare will cover the following complications of pregnancy under the policy:

- Caesarean delivery, where medically necessary
- Ectopic pregnancy
- Hydatiform mole
- Evacuation of retained products of uterus following Miscarriage and childbirth
- Induction of abortion for foetal abnormality
- Insertion of Shirodkar suture.

Medical treatment is allowed where your Obstetrician identifies the need and as authorised by the Society, this does not include delivery room costs for a normal or induced labour or for prolonged periods of bed rest to monitor a pregnancy.

Pre-authorisation

Approval given either verbally or in writing by the Society prior to any treatment taking place, as a guarantee that we will meet your treatment costs as part of an eligible claim – providing you are still paying premiums for the appropriate **your choice** option at the time of treatment.

Pre-existing conditions

Any disease, illness or injury for which

- you have received medication, advice or treatment; or
- you have experienced symptoms, whether the condition has been diagnosed or not in the 5 years before the start date of cover.

Prosthesis

A surgical appliance, such as a joint replacement and bone fixation, heart valve, pacemaker, stents, grafts and meshes, which are implanted by a Consultant/Specialist during a surgical procedure.

Related condition

Any symptom or condition, disease, illness or injury which is medically considered to be associated with another symptom or condition, disease, illness or injury will be considered as one claim.

Renewal date

Each anniversary of the commencement date of your membership as displayed on your Registration Certificate.

Routine monitoring

Regular consultations, check-ups, examinations or tests to assess your ongoing state of health.

Society

Civil Service Healthcare Society Limited.

Specialist/Consultant

A registered medical or dental practitioner who holds or has held a substantive NHS Consultant's post, or has a certificate of Higher Specialists Training in the relevant specialty issued by the appropriate Royal College and who holds a current General Medical Council Number and a current License to Practice; in accordance with EU medical directives.

Specialised scans

High cost scans such as:

- MRI & CT Scans
- PET Scans
- Myelogram
- Thallium Scans
- DAT & MIBG Scans
- Perfusion/Ventilation Scans.

Special terms

This refers to personal exclusions, general exclusions or conditions or restrictions to benefit which we may apply to your policy on joining, re-joining or transfer and which will be shown on your Registration Certificate.

Stable

A patient is able to be nursed in a general ward setting and does not require critical care including resuscitation, intensive care, high dependency or coronary care, life support or immediate life saving surgery.

Surgical procedure

An operation including open incision and/or laparoscopic procedures, used to correct an injury, disease or degenerative change; and also including endoscopic procedures performed as a day case procedure required to aid a diagnosis or to give therapeutic relief of symptoms.

Switch

The terms under which we will transfer your cover from another health insurer provided you have been insured within the last 60 days prior to joining and transfer your current underwriting terms to CS Healthcare. The two methods by which you can do this are Continued Personal Medical Exclusions (CPME) or Continued Moratorium (CM).

Treatment

Surgical or medical services (including diagnostic tests) that are needed to diagnose, relieve or cure a disease, illness or injury.

United Kingdom

England, Scotland, Wales, Northern Ireland, Channel Islands and Isle of Man.

We/Us/Our

Civil Service Healthcare Society Limited.

Year

The period of 12 calendar months from when the membership began or was last renewed. The policy year to which your benefits, co-payment or excess terms apply for each insured person.

You/Your

The member or any insured dependant.

For requesting a Claim Form and pre-authorising treatment contact the Claims Helpline on

020 8410 0440

claims@cshealthcare.co.uk

For general enquiries contact the Membership Services Team on

020 8410 0400

membership@cshealthcare.co.uk

For 24 hour health advice contact Lifeline

020 8410 0415

lifeline@healix.com

For care advice contact GraceCare

0800 137669

customerservices@graceconsulting.co.uk



Civil Service Healthcare Society Limited incorporated in England and Wales
Registered Office: Princess House, Horace Road, Kingston upon Thames,
Surrey, KT1 2SL. Civil Service Healthcare is a registered friendly society
authorised and regulated by the Financial Services Authority (FSA)
reg. no. 205346. Our products are covered by the Financial Services
Compensation Scheme (FSCS). In the interest of continuously improving our
services to members, your call may be recorded and may be monitored for
training, quality assurance purposes and/or prevention and detection of crime.



This brochure is printed
on recycled paper.